General

Guideline Title

Prevention with positives: integrating HIV prevention into HIV primary care.

Bibliographic Source(s)

New York State Department of Health. Prevention with positives: integrating HIV prevention into HIV primary care. New York (NY): New York State Department of Health; 2011 Apr. 28 p. [48 references]

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

The quality of evidence (I-III) and strength of recommendation (A-C) are defined at the end of the "Major Recommendations" field.

Prevention of Sexual Transmission

Key Point:

Prevention should be viewed as a lifelong activity that changes as patients progress through their lives. Effective risk-reduction counseling requires ongoing discussion and flexibility to adapt to patients' evolving needs and lifestyles.

Obtaining a Sexual Risk Assessment and History

Clinicians should obtain a baseline sexual risk assessment for all human immunodeficiency virus (HIV)-infected patients (see the table below). (AII)

Ongoing sexual risk assessments should occur at least every 3 to 4 months. The content and intensity of prevention interventions should be tailored as the clinician learns more about the patient's behaviors and health beliefs. (AIII)

Clinicians should stress the confidential nature of discussions and maintain a nonjudgmental attitude regarding sexual activities to encourage patients to be open and honest. (AIII)

Components of Sexual Risk Assessment

Clinicians should include the components listed in the table below when obtaining a baseline risk assessment. (AII)

Clinicians should assess whether HIV-infected women of childbearing potential might be pregnant or wish to become pregnant. Clinicians should discuss the importance of barrier protection in addition to contraception with women of childbearing potential who are not specifically considering pregnancy but are sexually active. (AI)

Clinicians should screen for alcohol and substance use at baseline and at least annually and should assess whether patients are more likely to engage in high-risk sexual activity while using. (AII)

Table: Elements of an Initial Sexual Risk Behavior Assessment

- Satisfaction with sex life (*Are you happy with your sex life? Do you find your sex life satisfying?*)
- History of sexually transmitted infections (STIs)
- Current STI symptoms
- Sexual practices, including vaginal, anal, digital, and oral sex
- Methods currently used to reduce risk, such as condom use
- Drug or alcohol use and sexual activity during use
- Exchanging sex for money, drugs, or a place to sleep
- Use of erectile dysfunction agents
- Methods of contraception and interest in conceiving
- Information about partners
    - Number of partners in the last 3 months
    - Age of partners*
    - Gender of partners
    - Where partners are met
    - Disclosure of HIV status to partners, discussion of safer sex with partners
    - HIV and STI status of partners

*Inquiring about the age of partners may be useful when obtaining a sexual risk assessment in younger men and women because it is often harder for them to negotiate safer sex with older partners.

Risk-Reduction Counseling for Sexual Transmission

Clinicians should:

- Routinely encourage HIV-infected individuals and their partners to adopt safer sexual practices. (AII)
- Educate HIV-infected patients about the risks associated with the patient's specific sexual behaviors. (AII) (See Table 4 in the original guideline document).
- Tailor messages according to the patient's relationship status and ongoing transmission risk behaviors. (AII) (See Appendix A in the original guideline document for examples of scripted dialogue that could be used for risk-reduction counseling).

Table: Elements of Risk-Reduction Counseling for Sexually Active HIV-Infected Patients

For patients who are sexually active, risk-reduction counseling should include the following:

- Review of safer sexual practices to prevent transmission of HIV and other STIs (see Table 4 in the original guideline document):
    - Instructions about consistent, correct male and female condom use
    - Importance of avoiding use of lambskin condoms and nonoxynol-9
    - Strategies to avoid intoxicating substances that can lead to unsafe sex, or if the patient is unwilling or unable to avoid these substances, discuss pre-planning when using drugs that lower inhibitions (e.g., have condoms available)
    - Avoidance of activities that irritate the mucosal surfaces before sex occurs, such as douching and use of sex toys or hyperosmolar lubricants
    - Avoidance of exposure to pre-ejaculatory fluid, because it may contain HIV
    - Reducing number of sexual partners, particularly those who are at-risk, such as those who are HIV-negative or of unknown status
- Clarification that an undetectable plasma viral load does not guarantee elimination of the risk of HIV transmission, even though it greatly

Table: Elements of Risk-Reduction Counseling for Sexually Active HIV-Infected Patients

- reduces the likelihood that HIV will be transmitted
- Reassurance that behaviors that do not involve exchange of or exposure to potentially infectious bodily fluids cannot transmit HIV
- How to communicate about HIV status with prospective sexual partners

Viral Load and Transmission Risk

Clinicians should educate HIV-infected patients about the following:

- Antiretroviral therapy (ART) is an important prevention strategy because it reduces viral burden, thereby reducing the risk of HIV transmission to sexual partners (AI)
- Adherence to ART is an achievable and important strategy because strict adherence enables ART to reduce transmission risk (AI)
- The use of condoms is still recommended for all patients, including those with undetectable viral load levels because an undetectable viral load does not completely eliminate the risk of HIV transmission (AI)

Safer Sexual Practices

Use of Barrier Methods

Clinicians or members of the healthcare team should educate HIV-infected patients about both male and female condoms and dental dams and should:

- Reinforce condom use for all sexually active patients, regardless of relationship status (AI)
- Provide patients with access to condoms (AI)
- Recommend polyurethane condoms for patients with latex allergy (AI)
- Advise patients to *avoid* using lambskin condoms or condoms that are lubricated with nonoxynol-9 (AI)
- Instruct patients about the effectiveness of different kinds of condoms and how to use condoms properly (AI)
- Advise patients to avoid oil-based lubricants with latex condoms (only water-based lubricants should be used); water- or oil-based lubricants can be used with polyurethane condoms (AI)
- Instruct patients about the use of dental dams during oral sex (BII)

Sexual Disinhibition Related to Alcohol and Substance Use

Clinicians should:

- Screen for alcohol and substance use at baseline and at least annually (AIII)
- Discuss how alcohol and substance use may affect decision-making regarding engagement in high-risk sexual behaviors (AIII)
- Help patients identify methods to either avoid substance use or to reduce HIV transmission risks while using substances (AII)
- Refer patients in need of treatment to substance use treatment services (AII) (See AIDS Institute Resource Directory for programs that provide substance use treatment services and harm-reduction counseling).

Partner Selection: Serosorting

Clinicians should discuss partner selection as a component of safer-sex education. For patients who choose to engage in serosorting and do not use condoms, clinicians should discuss the possible risks of acquiring or transmitting resistant HIV strains or other STIs. (BIII)

Clinicians should obtain more frequent STI screening for patients who report serosorting without the use of condoms. (AI)

Superinfection

Clinicians should educate HIV-infected individuals about the risk of acquiring a different strain of HIV from HIV-infected sexual and drug-using partners. (BIII)

The Role of STI Screening and Treatment

Clinicians should screen HIV-infected patients for STIs at baseline and at least annually (see Table 5 in the original guideline document). Clinicians should re-screen patients for STIs if they have had any new sex partners since the last screening, or if they report that their partner has had any new sex partners. (AI)

Clinicians should inquire about the following STI symptoms at baseline, annually, and when clinically indicated: (AI)

- Penile and vaginal/cervical discharges
- Ulcerative lesions
- Anorectal or pharyngeal pain
- Difficulty or pain during sex, urination, defecation, or menstruation
- Pruritus, burning, or bleeding in the anogenital area
- Rash
- For women, abdominal pain with or without fever

When an HIV-infected patient presents with symptoms or a diagnosis of an STI, clinicians should:

- Perform a risk assessment and provide appropriate risk-reduction counseling (AII)
- Consider both HIV exposure and STI exposure to partners
- Offer assistance with partner notification if needed, or refer patient to other sources for partner notification assistance (Contact Notification Assistance Program [CNAP], Partner Notification Assistance Program [PNAP]) (AI)

Key Point:

Early identification and treatment of STIs is a crucial prevention strategy. The risk of HIV transmission in patients co-infected with genital ulcer disease is increased by 2 to 6 times because of increased levels of HIV virus in semen and vaginal secretions.

Partner Notification

Clinicians should discuss the importance of partner notification with HIV-infected patients on a routine and ongoing basis for both new partners and previous partners who have not yet been notified. (AI)

Clinicians must discuss with HIV-infected patients their options for informing sexual and needle-sharing partners that they may have been exposed to HIV (New York State Public Health Law, Article 21, Chapter 163 of the Laws of 1998). Clinicians and/or patients should contact the New York State Department of Health Partner Services Program (1-800-542-AIDS) or the New York City Department of Health and Mental Hygiene Contact Notification Assistance Program (CNAP) (212-693-1419) for assistance with partner notification. (AI)

If a risk for domestic violence is identified, partner notification should be deferred and the patient referred to a domestic violence agency (see Section II. D. 3. Domestic Violence Screening below and in the original guideline document). (AI)

Key Point:

Based on recent evidence-based reviews, it is strongly recommended that all persons with newly diagnosed or reported HIV infection receive partner services with active health department involvement. Medical providers play a key role in actively linking patients to health department partner services throughout the continuum of care.

See the original guideline document for information on New York State HIV Reporting and Partner Notification (HIVRPN) Law.

Key Point:

Medical providers are required by law to report the names of sexual and needle-sharing partners of HIV-infected individuals who are known to the provider. Patients, however, are not required to disclose partner information, and their participation in partner notification programs is voluntary.

See Table 6 in the original guideline document for information on options for partner notification.

Key Point:

The HIVRPN Law allows physicians to notify known partners of an HIV-infected patient with or without patient consent, but only after informing the patient that notification is imminent. All other healthcare providers must have the patient's consent before proceeding with notification. Clinicians should contact Partner Services/CNAP for guidance and assistance with the partner notification process.

Domestic Violence Screening

As part of post-test counseling and partner notification, clinicians must screen HIV-infected men and women and their partners/contacts for risk of domestic violence related to partner notification (New York State Public Health Law Article 21 [1983], Public Health Law Article 27-F—HIV and AIDS Information; Public Health Law Article 21, Title III—HIV Reporting and Partner Notification; 1998). (AII)

Clinicians should be familiar with local domestic violence agencies and the mechanisms of referral for patients with identified risk of domestic violence resulting from partner notification. (AIII)

Non-Occupational Post-Exposure Prophylaxis (nPEP)

Clinicians should educate HIV-infected patients and their families at initial visits and annually about nPEP. Such counseling should include the benefits and limitations of nPEP. (BII)

The clinician or a member of the HIV care team should provide risk-reduction counseling and primary prevention counseling whenever someone is assessed for nPEP, regardless of whether PEP is initiated. (AII)

Non-occupational PEP should not be routinely dismissed solely on the basis of repeated risk behavior or repeat presentation for nPEP. Persons who present with repeated high-risk behavior or for repeat courses of nPEP should be the focus of intensified education and prevention interventions and should be considered candidates for pre-exposure prophylaxis (PrEP). (AIII)

Prevention of HIV Transmission Secondary to Substance Use

Obtaining a Substance Use History and Screening for Substance Use

Clinicians should:

- Obtain a baseline substance use history for all HIV-infected patients (see the table below) (AIII)
- Screen all HIV-infected patients for substance use at baseline and at least annually. Screening questions should be phrased to include alcohol and prescription and nonprescription drug use (AIII)
- Stress the confidential nature of discussions regarding substance use to encourage patients to be open and honest (AIII)
- Be familiar with the names and routes of administration of commonly used street drugs (see What Are These Drugs?) (AIII)

When substance use risk is identified, clinicians should help the patient develop individualized goals to prevent transmission, such as abstinence, reduced use, or safer use, and should address the issue at subsequent routine visits. (AII)

Table: Elements of a Baseline Substance Use History

Current and Past:

- Types of drugs (past and current use)
  - Street drugs (e.g., marijuana, cocaine, heroin, "crystal" methamphetamine, 3,4-Methylenedioxymethamphetamine (MDMA)/ecstasy, ketamine)
  - Prescription drugs (illicit use)
  - Alcohol
  - Injectable hormones
- Frequency of use and usual route of administration
- Sexual risk-taking while under the influence of drugs or alcohol
- Sharing needles or other injection equipment
- Number and HIV status of needle-sharing partners
- Exchanging sex for drugs
- History of treatment and actual or perceived barriers to treatment

Table: Elements of a Baseline Substance Use History
• Methods of risk reduction and success of these methods

Risk-Reduction Counseling for Transmission Related to Substance Use

Clinicians should discuss behavioral risk-reduction measures on a routine and ongoing basis with patients who use substances and/or consume alcohol. These discussions should include use of barrier protection, how to speak with partners about safer sex, and the circumstances under which high-risk sexual behavior might occur. (AII)

Clinicians should discuss avoidance of needle/syringe-sharing activity with all injection drug users, regardless of viral load, to prevent HIV transmission. Clinicians should issue prescriptions for new needles and syringes to patients who inject drugs and should discuss options for accessing new needles and syringes, including use of the Expanded Syringe Access Demonstration Program and Syringe Exchange Programs, New York State's two syringe access initiatives. (AI)

Clinicians should refer patients for substance use treatment and/or mental health services, when the need is identified and readiness established.

Definitions:

Quality of Evidence for Recommendation

I. One or more randomized trials with clinical outcomes and/or validated laboratory endpoints
II. One or more well-designed, non-randomized trials or observational cohort studies with long-term clinical outcomes
III. Expert opinion

Strength of Recommendation

A. Strong recommendation for the statement
B. Moderate recommendation for the statement
C. Optional recommendation

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Human immunodeficiency virus (HIV) infection

Guideline Category

Counseling

Prevention

Risk Assessment

Clinical Specialty

Allergy and Immunology

Family Practice

Infectious Diseases

Internal Medicine

Obstetrics and Gynecology

Preventive Medicine

Intended Users

Advanced Practice Nurses

Health Care Providers

Nurses

Physician Assistants

Physicians

Public Health Departments

Substance Use Disorders Treatment Providers

Guideline Objective(s)

- To provide guidelines for integrating human immunodeficiency virus (HIV) prevention into HIV primary care
- To focus on the importance of ongoing secondary prevention efforts, sometimes referred to as "prevention with positives"

Target Population

- Human immunodeficiency virus (HIV)-infected patients
- Partners of HIV-infected patients

Interventions and Practices Considered

1. Obtaining baseline risk assessment for all human immunodeficiency virus (HIV)-infected patients
2. Ongoing risk assessment, with preventive interventions tailored to risk
3. Maintaining confidentiality and non-judgmental attitude
4. Assessing pregnancy status of infected women
5. Screening for and addressing alcohol and substance abuse
6. Risk-reduction counseling tailored to safer sex practices
7. Educating patients on viral load, transmission risk, and the importance of adherence to antiretroviral therapy
8. Educating patients on barrier methods to prevent HIV transmission (male and female condoms, dental dams)
9. Discussing partner selection and serosorting as components of safer-sex education
10. Educating individuals about the risk of acquiring a different strain of HIV from HIV-infected sexual and drug-using partners
11. Screening for, treatment of, and risk-reduction counseling regarding other sexually transmitted infections (e.g., syphilis, gonorrhea, chlamydia, human papillomavirus infection)
12. Discussing importance of partner notification
13. Screening for domestic violence and referring patients to domestic violence agency, if needed
14. Reporting the names of sexual and needle-sharing partners of HIV-infected individuals who are known to the provider (as required by New York State law)
15. Educating patient and families about non-occupational post-exposure prophylaxis (nPEP)

Major Outcomes Considered

Effectiveness of prevention

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Not stated

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Quality of Evidence for Recommendation

I. One or more randomized trials with clinical outcomes and/or validated laboratory endpoints
II. One or more well-designed, non-randomized trials or observational cohort studies with long-term clinical outcomes
III. Expert opinion

Methods Used to Analyze the Evidence

Review

Review of Published Meta-Analyses

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

AIDS Institute clinical guidelines are developed by distinguished committees of clinicians and others with extensive experience providing care to

people with HIV infection. Committees* meet regularly to assess current recommendations and to write and update guidelines in accordance with newly emerging clinical and research developments.

The Committees* rely on evidence to the extent possible in formulating recommendations. When data from randomized clinical trials are not available, Committees rely on developing guidelines based on consensus, balancing the use of new information with sound clinical judgment that results in recommendations that are in the best interest of patients.

*Current committees include:

- Medical Care Criteria Committee
- Committee for the Care of Children and Adolescents with HIV Infection
- Dental Standards of Care Committee
- Mental Health Guidelines Committee
- Committee for the Care of Women with HIV Infection
- Committee for the Care of Substance Users with HIV Infection
- Physicians' Prevention Advisory Committee
- Pharmacy Advisory Committee

Rating Scheme for the Strength of the Recommendations

Strength of Recommendation

A. Strong recommendation for the statement
B. Moderate recommendation for the statement
C. Optional recommendation

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Description of Method of Guideline Validation

All guidelines developed by the Committee are externally peer reviewed by at least two experts in that particular area of patient care, which ensures depth and quality of the guidelines.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for selected recommendations (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Decreased human immunodeficiency virus (HIV) transmission from patients known to be infected

- Preventing patients with established HIV infection from acquiring new strains of HIV (superinfection) or other sexually transmitted infections (STIs)

Potential Harms

Not stated

Qualifying Statements

Qualifying Statements

When formulating guidelines for a disease as complex and fluid as human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), it is impossible to anticipate every scenario. It is expected that in specific situations, there will be valid exceptions to the approaches offered in these guidelines and sound reason to deviate from the recommendations provided within.

Implementation of the Guideline

Description of Implementation Strategy

The AIDS Institute's Office of the Medical Director directly oversees the development, publication, dissemination and implementation of clinical practice guidelines, in collaboration with The Johns Hopkins University, Division of Infectious Diseases. These guidelines address the medical management of adults, adolescents and children with human immunodeficiency virus (HIV) infection; primary and secondary prevention in medical settings; and include informational brochures for care providers and the public.

Guidelines Dissemination

Guidelines are disseminated to clinicians, support service providers and consumers through mass mailings and numerous AIDS Institute-sponsored educational programs. Distribution methods include the HIV Clinical Resource website, the Clinical Education Initiative (CEI), the AIDS Educational Training Centers (AETC) and the HIV/AIDS Materials Initiative. Printed copies of clinical guidelines are available for order from the New York State Department of Health (NYSDoH) Distribution Center for providers who lack internet access.

Guidelines Implementation

The HIV Clinical Guidelines Program works with other programs in the AIDS Institute to promote adoption of guidelines. Clinicians, for example, are targeted through the CEI and the AETC. The CEI provides tailored educational programming on site for health care providers on important topics in HIV care, including those addressed by the HIV Clinical Guidelines Program. The AETC provides conferences, grand rounds and other programs that cover topics contained in AIDS Institute guidelines.

Support service providers are targeted through the HIV Education and Training initiative which provides training on important HIV topics to non-physician health and human services providers. Education is carried out across the State as well as through video conferencing and audio conferencing.

The HIV Clinical Guidelines Program also works in a coordinated manner with the HIV Quality of Care Program to promote implementation of HIV guidelines in New York State. By developing quality indicators based on the guidelines, the AIDS Institute has created a mechanism for measurement of performance that allows providers and consumers to know to what extent specific guidelines have been implemented.

Finally, best practices booklets are developed through the HIV Clinical Guidelines Program. These contain practical solutions to common problems related to access, delivery or coordination of care, in an effort to ensure that HIV guidelines are implemented and that patients receive the highest level of HIV care possible.

Implementation Tools

Resources

Slide Presentation

Staff Training/Competency Material

Tool Kits

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Living with Illness

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

New York State Department of Health. Prevention with positives: integrating HIV prevention into HIV primary care. New York (NY): New York State Department of Health; 2011 Apr. 28 p. [48 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2011 Apr

Guideline Developer(s)

New York State Department of Health - State/Local Government Agency [U.S.]

Source(s) of Funding

New York State Department of Health

Guideline Committee

Physicians' Prevention Advisory Committee

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the New York State Department of Health AIDS Institute Web site .

Availability of Companion Documents

The following are available:

- Prevention with positives: young MSM. Available as a slide presentation and CME course from the New York State Department of Health AIDS Institute Web site.
- Prevention for positives and negatives. Available as a slide presentation and CME course from the New York State Department of Health AIDS Institute Web site.

- PozKit: A prevention with positives toolkit for clinicians. Available to subscribers from the New York State Department of Health AIDS Institute Web site.

In addition, Appendix A of the original guideline document contains examples of scripted dialogue for risk-reduction counseling related to sexual transmission. Appendix B contains information on types of condoms and proper use.

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on October 27, 2011.

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